Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Hypnotic Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Doral (single-source brand-name benzodiazepine) and any brand-name multiple-source benzodiazepine that has an FDA "A"-rated generic equivalent as identified by the ***Approved Drug Products with Therapeutic Equivalence Evaluations*** (also called the "Orange Book").

PA is also required for quantity requests greater than 10 units per month for hypnotics. Additional information about hypnotic use can be found within the MassHealth Drug List at **www.mass.gov/masshealth.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Hypnotic request	**Quantity**
☐ Ambien (zolpidem)	
☐ Dalmane # (flurazepam)	
☐ Doral (quazepam)	
☐ Halcion # (triazolam)	
☐ ProSom # (estazolam)	
☐ Restoril # (temazepam)	
☐ Sonata (zaleplon)	
☐ Other _____	

Dose, frequency, and duration of requested drug

Drug NDC (if known)

A. If request is for Doral or any brand-name multiple-source benzodiazepine (as denoted by the # symbol), please complete Sections **I** and **II**.

B. If request is for quantities greater than 10 units per month, please complete Section **II**.

Section I

Please complete this section for requests for Doral or brand-name multiple-source benzodiazepine.

Attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

Has member tried a generic benzodiazepine?

☐ Yes. Please complete the following information.

Drug name

Dates of use

Dose and frequency

☐ No. Explain why not.

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

☐ No.

Medication information

Section II

Please attach supporting documentation (e.g., copies of medical records, office notes, sleep evaluation) for your response to **each** question.

If the request is for quantities greater than 10 units per month of a hypnotic, please attach a detailed description of your treatment plan of the condition for which you have requested the hypnotic. Include all nonpharmacologic and pharmacologic interventions, therapeutic endpoints, and a list of the member's current medications.

A. Indication for hypnotic

☐ Acute insomnia ☐ Transient insomnia

☐ Other _____

B. Is insomnia secondary to a vital concurrent medication or diagnosis?

☐ Yes. Briefly describe and attach documentation.

☐ No.

C. Has member had a sleep evaluation?

☐ Yes. Briefly describe and attach documentation.

☐ No. Explain why not.

D. Has member been counseled on good sleep hygiene practices?

☐ Yes. Briefly describe and attach documentation.

☐ No. Explain why not.

E. Is request for quantities greater than 10 units per month of a hypnotic?

☐ Yes. Briefly describe and attach documentation, including detailed treatment plan.

☐ No.

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date